INSTRUCTIONS FOR COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)
This form to be used for NC Medicaid and/or Health Choice service requests.
Revised March 2007

Please note: To ensure timely processing of your ITR, please complete all sections for submission to ValueOptions. TYPE or PRINT LEGIBLY. Check/Circle responses where applicable.

For Concurrent Reviews:
- A new form is required for each concurrent review.
- Admit dates need to match the initial review.

Preliminary information:

Information requested	How to complete this section
Requested Start Date for this Authorization	Enter the admission date for a new request or the first day of a continued stay request
Level of Care	• Check appropriate box. If *Other*, designate service requested **without** using acronyms. • Crisis Stabilization Unit, Intensive in-home, Multisystemic Therapy, Assertive Community Treatment Team, Day Treatment, Partial Hospitalization, Psychosocial Rehab, Community Support, SA services such as medically managed residential, non-medically managed residential, SA Comprehensive Outpatient Treatment, non-medical detox. **(for Health Choice only: Multisystemic Therapy or Intensive In-Home)** • For Group Home indicate Level II, III, or IV and how many beds.
Treatment Unit/Program	If the consumer is on a specialty unit please advise, i.e. Eating Disorder Unit. Ignore this item for expanded services. Use this line only for inpatient or residential care.
Type of care	• Prospective: check this if the consumer has never received this level of care from your agency. • Concurrent: check this if the consumer is currently receiving this level of care from your agency. • Discharge: check this if the consumer is being released from this level of care. • Retrospective: check this if the consumer has already been admitted to and discharged from the program prior to submission of this form. This kind of authorization is only used when the consumer has retro-eligibility.
Precipitating Event	• What specific **current** behaviors has the consumer exhibited causing you to request this service? Include root cause or particular history. Include progress or lack of progress during the reporting period. • Diagnosis should not be entered here.
Member's Current location	Indicate where the consumer is living at this time.

INSTRUCTIONS FOR COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)
This form to be used for NC Medicaid and/or Health Choice service requests.
Revised March 2007

Demographics:

Information requested	How to complete this section
Member's Name	Enter the consumer's name as it appears on the Medicaid or Health Choice card
Date of Birth	Enter the consumer's date of birth
Member/Policyholder ID#	This is the ID# from the consumer's benefit card. For Medicaid, use Medicaid #. For Health Choice, enter ID#. It is the provider's responsibility to enter the correct number.
Tel #	Enter the telephone number for the consumer if available
Member's City/State	Enter the consumer's complete address (including street address, city and state)
Insured's Employer/Benefit Plan	Enter "Medicaid" or "Health Choice"
Facility	The name of the facility providing the service.
Facility ID#	• Do not enter facility tax ID# • Enter Medicaid provider number with appropriate alpha suffix for expanded services.
Facility Address/City/St	Enter the complete address of the facility/program where consumer is receiving treatment. The address entered should match the address associated with the Medicaid # on file with DMA.
Attending Provider	Enter the provider who will follow the consumer throughout the course of treatment. This will be the case manager, QP (qualified professional), or whoever the primary clinical person working with this member is.
Attending's Phone #	Enter the phone # where the attending can be most easily reached
UR Name	Enter the name of the contact person at the facility/program for clinical reviews / additional information
UR Phone #	Enter the phone # where the UR contact can be most easily reached
UR Fax #	Enter the fax # for the UR dept

DSM-IV Diagnosis:

Information requested	How to complete this section
Axis I through IV	• There must be at least one valid diagnosis per authorization request. Use codes and descriptions. • All DSM Axis information is preferred, but at minimum there must be an Axis 1 or II Diagnosis for MH/SA related services and an Axis II Diagnosis for developmental disability related services. • Please see most current DSM for further instructions.

Current Risks:

Information requested	How to complete this section
Risk to self (SI)	Indicate consumer's **current** level of, or absence of, suicidality by circling the appropriate value, and checking all boxes that apply. **This must be completed for any value great than "0". Be specific.**
Risk to others (HI)	Indicate consumer's **current** potential for, or absence of, violence and/or abuse by circling the appropriate value, and checking all boxes that apply. **This must be completed for any value greater than"0". Be specific**.

INSTRUCTIONS FOR COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)
This form to be used for NC Medicaid and/or Health Choice service requests.
Revised March 2007

Attempts or Gestures:

Complete this section only if the consumer is a risk to self or others.	
Information requested	**How to complete this section**
Current Serious attempts	Has a serious attempt occurred during this course of treatment? If *yes* circle SI and/or HI as appropriate.
Prior Serious attempts	Has serious attempts occurred in the past? If *yes* circle SI and/or HI as appropriate.
Prior Serious gestures	Have there been serious gestures in the past? If *yes* circle SI and/or HI as appropriate.
Date of the most recent attempt or gesture	Enter the date of attempt or gesture. VERY IMPORTANT field to complete. DO NOT SKIP if any of previous fields have been marked greater than "0" or *yes*.

Current Impairments: (Please select/circle one value for each type of **current** impairment. The rating of **current** impairments should correspond with other clinical information being identified, such as precipitant events, diagnosis, PCP assessment, etc.)

Rating	**Definition**
0 = none	No evidence of impairment
1 = mild	Occasional impairment or difficulties, but no interference with normal daily activities
2 = Moderate	Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks
3 = Severe	Currently experiencing severe symptoms, potential risk for harm to self/others, severe distress and/r disruption in daily activities
N/A = not assessed	Impairment was not assessed – **Please note use of N/A may result in additional calls from ValueOptions to collect this information.**

Mental Health/Psychiatric Treatment History: (If none or unknown please check *none* or *unknown*. If known, check all that apply and complete the following)

This section refers to the last twelve (12) months.	
Information requested	**How to complete this section**
Outcome	Check appropriate outcome
Treatment Compliance (non-med)	Check appropriate level of compliance Compliant with aspects of their treatment that do not include medications. • Poor -- Member complies with few (Less than 50%) of the recommendations in his/her treatment plan. • Fair -- Member complies with some (More than 50% but less than 75%) of the recommendations in his/her treatment plan. • Good -- Member complies with most (At least 75%) of the recommendations in his/her treatment plan
Number of psychiatric hospitalizations in the past 12 months	Indicate the total number of "24 hour events" for Psychiatric Hospitalization/Residential Care in the past 12 months. An estimate is acceptable.
Number of psychiatric hospitalizations in lifetime	Indicate the total number of "24 hour events" for Psychiatric Hospitalization in his/her lifetime. An estimate is acceptable.

INSTRUCTIONS FOR COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)
This form to be used for NC Medicaid and/or Health Choice service requests.
Revised March 2007

Substance Abuse Treatment History:

Information requested	How to complete this section
Outcome	Check appropriate outcome
Treatment Compliance (non-med)	Check appropriate level of compliance Compliant with aspects of their treatment that do not include medications. • Poor -- Member complies with few (Less than 50%) of the recommendations in his/her treatment plan. • Fair -- Member complies with some (More than 50% but less than 75%) of the recommendations in his/her treatment plan. • Good -- Member complies with most (At least 75%) of the recommendations in his/her treatment plan
Number of substance abuse hospitalizations in the past 12 months	Indicate the total number of "24 hour events" for Substance Abuse Hospitalization/Residential Care in the past 12 months. An estimate is acceptable.
Number of substance abuse hospitalizations in lifetime	Indicate the total number of "24 hour events" for Substance Abuse Hospitalization in his/her lifetime. An estimate is acceptable.

Other Treatment History:

Information requested	How to complete this section
Workplace referral/EAP/disability benefits/psychotropic meds	Not applicable for NC Medicaid or Health Choice. Please disregard this section.
Current Psychotropic Medications	Check applicable box – if *Yes*, list all medications being used for treatment of a psychiatric and/or substance abuse condition, including dose, frequency, and adherence. Any other medications that are pertinent for the treatment of major medical conditions may also be listed.

Substance Use/Abuse: If yes, please complete below

Information requested	How to complete this section
Substance Use/Abuse	Check applicable box – if *Yes*, complete information below
Substance, Total Yrs Use, Length current use, amount, frequency chart	List all known information - An estimate is acceptable.
Withdrawal Symptoms	If this is a Substance Abuse admission this needs to be complete
Vitals	Enter all required information
UDS	Indicate if completed
Outcome	Check appropriate box
Longest period of sobriety	Check appropriate box
Relapse Date	What is the most recent Relapse date?

Withdrawal symptoms:

Complete this section with current symptoms.

Vitals:

Complete this section only if the consumer is in detox.

ASAM Dimensions:

Complete this section only if there is an SA issue. ASAM Dimensions are the determining factor for medical necessity. For further information about ASAM Dimensions, see the web site of the American Society of Addiction Medicine at www.asam.org.	
Information requested	**How to complete this section**
Intoxicated/Withdrawal Symptoms	• Low – Not under the influence; no withdrawal potential • Medium – Recent use, potential for intoxication; presenting with initial withdrawal symptoms • High – Severe withdrawal history; presenting with seizures, CIWA score greater than 10
Biomedical Conditions	• Low – No current medical problems; no diagnosed medical condition; no care from PCP or prescribed meds • Medium – Diagnosed medical condition; care from PCP; problematic response to conditions and/or care • High – Life threatening medical condition; medical problems interfering with treatment; hospitalization needed
Emotional/Behavioral/Cognitive	• Low – No current cognitive/emotional/behavioral conditions • Medium – Psychiatric Symptoms, including cognitive, emotional, behavioral; complications interfering with recovery efforts • High – Active DTO/s, S/HI; destructive, violent, or threatening behaviors, refusing to attend program schedule
Readiness for Change	• Low – Accepting need for treatment; attending, participating, and can ID future goals, plans • Medium – Ambivalent about treatment; seeking help to appease others; avoiding consequences • High – Denial of need for treatment despite severe consequences; refusing or is unable to engage due to DIM3, DIM5 symptoms interfering
Relapse Prevention	• Low – Recognizes onset signs; uses coping skills with CD or psychiatric problems • Medium – Limited awareness of relapse triggers or onset signs • High – Beliefs problematic re: continued CD use despite attendance; revisions in treatment plan; unable to recognize relapse triggers or onset signs, or recognize and employ coping skills
Recover Environment	• Low – Supportive Recovery environment, with accessible MH, CD Support • Medium – Moderately supportive with problematic access to MH, CD support • High – Environment does not support recovery behaviors or efforts; resides with active substance users or abusive individuals

INSTRUCTIONS FOR COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)
This form to be used for NC Medicaid and/or Health Choice service requests.
Revised March 2007

Treatment Request:

This section is for all treatment requests, including both mental health and substance abuse.	
Information requested	**How to complete this section**
Admit Date	• Enter date of this admission. • Same admit date should be listed on all concurrent ITRs. This is not the same as the start date of this request as is found on top of page 1. • For expanded services, admit date = the date of first contact with this patient by your agency.
Is family/couples therapy indicated?	Check Yes or No and date of appointment if Yes
Involuntary; Court Ordered; Fixed Length Program	Check applicable box
Frequency of program	• Indicate the specific request for this level of care and duration. Indicate hours or units. Indicate group or individual setting. Be specific. Example: 5hr/wk for three months • **Must match the PCP form.** • PCP /SO form needs to be included and should explain the purpose of the hours and frequency.
Reason for continued stay	Check all that apply
Barriers to discharge	Check all that apply
Baseline Functioning	Check all that apply

Discharge Plan:

Information requested	**How to complete this section**
Expected D/C Date if known	Enter the date consumer is expected to discharge
Estimated Return to work date	For Adults ONLY (this does not apply to children under Medicaid and Health Choice)
Planned D/C level of care	This should be completed during both admission and continued stay reviews
Planned D/C Residence	Check appropriate box

INSTRUCTIONS FOR COMPLETING THE VALUEOPTIONS INPATIENT TREATMENT REPORT (ITR)
This form to be used for NC Medicaid and/or Health Choice service requests.
Revised March 2007

Discharge Information: To be completed upon discharge

A new ITR should be completed when discharge occurs. Do not simply add on to original form. Change in status at time of discharge compared to entry status is very important. If discharge information is not available, do not submit a new ITR form.	
Information requested	**How to complete this section**
Actual Discharge Date	Date consumer was discharged from the program
Primary Discharge Diagnosis	Primary Diagnosis upon discharge from the program
Discharge GAF:	GAF score upon discharge from the program
Discharge Condition	Has the consumer's condition improved, worsened or had no change from onset of treatment? Please check appropriate box.
Treatment involved the following	Check all that apply. **This must be completed.**
Total # Days/Sessions used	The total number of days/sessions used during this course of treatment
Discharge plans in place?	**This must be completed.**
Member/Family Member name for follow up	List relative with whom consumer has most contact.
Relationship	How is the person related to the consumer?
Phone Number	Telephone number where consumer or family member can most likely be reached. If unknown, please check box "don't know".
AfterCare Behavioral Health Provider	If arranged, enter provider's name, telephone #, scheduled appointment date and type of appointment. If Member leaves service against medical advice, check *Do not know*.
Prescribing Physician	If arranged, enter the physician's name, telephone #, check what type of physician it is and appointment date
Signature of Person Completing this Form	Signature of Provider of Services.